Nottinghamshire County Council

Quality Monitoring Audit Form

Radcliffe Manor House Residential Care Home

Home Name:	Radcliffe Manor House Care Home		
Manager: (Are they registered with the CQC?)	Mrs Melanie Gayle Barron (CQC Registered)		
Provider:	Home of Rest for Old People Also Known as Radcliffe Manor House		
Type of Service:	Residential Dementia Care		
Home Address:	52 Main Street, Radcliffe on Trent, Nottingham, NG12 2AD Telephone no: 0115 9110138		
Email Address:	melbarron@radcliffemanorhouse.co.uk		
Date of Audit:	19 October 2021		
Band:	5	Previous Band:	5
Score:	51/57	Action Plan Required?	No

Key:	**Excellent**	**Good**
	Improvement Required	**Does Not Meet**

Standard One: People who use the service experience outcome focussed person centred care: People who receive a care service receives outcome focussed person-centred care, which considers their choices and preferences. Care is provided in a positive risk-taking environment, which supports people to make decisions regarding their care.

1.1 Each service user has a personalised support plan which identifies patterns of daily living. Service users and / or families / advocates are involved in the process and are able to contribute their views.

Score	Recommendations:	Observed Evidence
Good	Ensure care plan review evaluations contained more detail to show what has been looked at and who has been involved in the review process.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was good. We spoke with residents living at the home, residents told us they were very happy with the care they received. We looked at a sample of care plans and found these were person centred and were completed with the resident and families, (Where appropriate), upon admission and found they detailed the level of support required. We found the care plans are reviewed on a regular basis and the resident was involved unless they stated otherwise. Within the care plans we looked at [5] we found the reviews were taking place. However, we felt the documented review evaluations required more detail. For example, “care plan remains relevant”. Manager told us they would address this. We found that residents’ personal choices, preferences and equality and diversity needs were considered with in the care plans. Where decisions regarding changes to the support of residents, the resident was included in the decision-making process (wherever possible). Recordings seen show relatives are included where possible. We found likes, dislikes and preferences were recorded, and this also included what type of activities they would like to be involved with. Activities were taking place in the home at the time of this audit visit.

1.1 Each service user has a personalised support plan which identifies patterns of daily living. Service users and / or families / advocates are involved in the process and are able to contribute their views.		
		This means each resident has a personalised assessment and care plan that identifies, through inclusion, the patterns of daily living in relation to their assessed needs, individual's wishes, choices, goals and sets out how the support, care and/or treatment is to be delivered. Review evaluations require more detail.

1.2 Care / support plans include identified areas of risk and details how these will be managed and are reviewed, supporting service users to make informed choices.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure all window restrictors in residents' rooms are checked regularly and recorded. This includes room twenty. Ensure mattress check audits are completed regularly and recordings support any actions that need addressing. Ensure air flow mattresses used have the settings recorded in the resident's respective care plan and that these settings are checked regularly to prevent any risk to resident's pressure areas.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was good. We looked at a sample of care plans and found where a risk was identified a corresponding risk assessment was in place. We looked at the care plan for one resident who was identified as needing support with moving and handling. We looked at the daily records and found the risk assessment was working as expected. We saw changes in needs were used to update the risk assessment. Where actions had been identified to minimise the risk, these actions were put in place. Personal emergency evacuation plans (PEEPS) are in place and reviewed. We looked in room twenty and found that the window restrictors in this occupied resident room were not in place. The manager saw this. We spoke with the manager about this and they apologised and told us they would address this sooner rather than later. We also found that mattress audits required completion for 2021. The manager told us these audits are to commence soon. Care plans for residents who have an airflow mattress in place are to contain air flow mattress setting figures pertinent to the individual. The manager told us they would review this. This means care plans include identified areas of risk and detail how these will be managed. They are reviewed within appropriate timescales. Personal emergency evacuation plans (PEEPS) are in place. Mattress audit to commence and air flow mattress setting figures to be care planned and reviewed.

1.3 Accurate records relating to service users are completed in a timely way and stored in a safe place.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We spoke with a resident regarding their involvement in their care/support. The resident said, “They check I’m happy with my care plan”. We looked at daily records regarding what residents were involved in each day. We found that these records were relatively detailed. We found that all residents care plans and documentation is stored away safely when not in use. This means residents are telling us they are involved in the care planning process and can contribute their views, opinions and understanding. Confidentiality regarding protecting resident’s details is upheld.

1.4. Service users are afforded a choice of suitable nutritious food and in sufficient amounts in accordance with their identified needs and wishes.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We spoke with residents regarding the quality and choice of food. They said, “I like the meals” and “Lots to eat”. We observed the lunchtime meal and found this was a very sociable occasion. Staff were seen assisting residents where needed. We found the staff to be kind and respectful to the people they care for. We found Nutritional assessments had been completed where required. We looked at the training records and found staff have competed any relevant training. For example, hydration and nutrition. We spoke with staff and they provided us with records and information to support residents likes, dislikes, preferences, special dietary needs, and any allergies. This means residents are afforded a choice of suitable nutritious food and in enough amounts for their needs in accordance with their identified needs and wishes. Relevant professionals are involved where required.

1.5. Service users are supported with dignity through individual stages of life, by staff respecting their choices and preferences.

Score	Recommendations:	Observed Evidence
Good	Ensure care plans contain information and details about resident's end of life care specifics (last wishes and preferences).	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was good. We looked at [4] care plans found some care plans that documented person-centred end of life care specifics. They included considerations of the residents' preferences and wishes regarding care, support, and treatment. We also found care plans that required more detail. For example, some care plans contain completed RESPECT forms and other didn't. We spoke with the manager about this. We looked at the care plan for one resident who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. We found this had been completed appropriately and was in line with the MCA requirements. We looked at the associated care plan and found this had been documented. We saw the resident had been included in the decision regarding the DNACPR. Staff have received end of life care (EOLC) training. This means residents are mostly supported with dignity through individual stages of life, by staff respecting their choices and preferences. Staff have received end of life care and dignity training.

Standard Two: Keeping People Safe: People are protected from abuse or the risk of abuse, including financial abuse and the safe handling of their medication. People are supported and needs are met in line with MCA and DoLs / DoLiC requirements.

2.1 Service users are protected from abuse or risk of abuse. Their human rights are upheld through the effective operation of safeguarding arrangements. These identify and prevent abuse and are responded to appropriately.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We looked at the safeguarding procedures and found this to be detailed and included the contact details for Nottinghamshire County Council's adult safeguarding team (MASH). We spoke with staff regarding their understanding of adult safeguarding and found they knew what abuse is and how to report this, using the local reporting requirements. We looked at the training records and found staff had completed safeguarding training. We looked at the safeguarding folder which contained the safeguarding information for all referrals, investigation outcomes. We found this folder to be well organised, divided into sections (for easy use) and indexed. On discussion with the manager they were able to provide a good knowledge and understanding of the safeguarding pathway and referral procedures for safeguarding. This means residents are protected from abuse or risk of abuse. Staff have completed the training they require regarding safeguarding procedures.

2.2 Where the service user lacks capacity to make decisions, the requirements of the Mental Capacity Act 2005 are met.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We looked at a sample of care plans and found people that lack capacity around their care and treatment are assessed. We found Mental capacity and best interests'(MCA/BI) assessments had been completed. We looked at staff training records and found that staff had received Mental capacity act (MCA) training, within the last 12 months. This means the requirements of the mental capacity act (MCA) are met. Staff have received the appropriate training.

2.3 Service users are protected and supported to live with the least restrictions to their liberties. Where the service user is subject to restrictions and restraint, they must be authorised under the Deprivation of Liberty Safeguards (DoLS) and Deprivation of Liberty in Community referred to in Nottinghamshire as (DoLiC).		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. Records seen show that any DoLs referrals have been submitted and have been and are being managed appropriately. For example, any conditions are looked at and transferred and used in the respective care plan for the resident. Any actions are addressed. Statutory notifications are completed and forwarded to the Care quality commission (CQC). Training records seen show that the staffing team have received DoLs training. This means the requirements of Deprivation of Liberty Safeguards (DoLs) are met. Staff have received Deprivation of liberty safeguards (DoLS) training.

2.4 Service users are protected from financial or material abuse.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We did not speak with residents regarding whether they had access to money being kept safe by the care home provider. We spoke with the management about resident finances (weekly personal allowances). The management told us they do hold some money for residents. We looked at the records for this. For example, DE: Records say £3.63p held by the provider and records suggest £3.63p (all correct). Also, PE: Records say £27.46p held by the provider (checked and all is correct). We asked the

2.4 Service users are protected from financial or material abuse.		
		manager if they hold any residents credit, debit or bank cards and PIN numbers and they told us they don't hold any. Receipts are provided and obtained for purchases and deposits of money to the top up money floats. This means that residents are protected from financial abuse.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure the pharmacist is contacted and provides written confirmation about the best, safe ways to hide and disguise medication via covert means for NT. Ensure a risk assessment is competed specifically for the covert medication administration for: NT and review this in line with the covert medication care plans month or sooner if needed. Ensure all handwritten medication MAR charts contain two staff initials to evidence information has been transferred and written correctly on the handwritten	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard is good. We did not speak with residents or relatives about medication. We requested that the provider show us their medication policies and procedures, they complied with our request. This also included policies regarding the administration of covert medication. We looked at the care plans for [6] residents and found that these included considerations of their medication. We saw that where changes in medication had been made, care plans were updated accordingly. We found care plans described how residents preferred to receive their medication, and our observations demonstrated this to be true. We found where people were identified as lacking the mental capacity to make decisions regarding their medication, best interest decisions are appropriately completed (as and when needed). There is one resident currently receiving their medication covertly. Manager to obtained written confirmation regarding acceptable ways of hiding and disguising medication for: NT from the pharmacist. Also, to implement a completed risk assessment for covert medication. The manager told us they would address this.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

	MAR. Two staff to check all handwritten MAR every time. Ensure all medication cream dispensers, tubes and containers have a date of opening and a date of discard recorded on them. Use stickers for this purpose.	We looked at the storage of medicines and found that this was in line with the provider's policies and procedures. We saw medication trolleys used are secured to a wall in the clinic room, when not in use. We saw there was a daily record of medication fridge and clinic room temperature measurements, and these were in line with best practice guidelines. All up to date. We looked at the system for ordering residents' medicines. We found the system ensured there was enough quantities in stock to meet individual residents' needs and in line with their prescriptions. We looked at the homely remedies and found these were being managed appropriately and safely and in line with the provider's procedures. We looked at the system used for the disposing of medicines, and found the records matched the quantities of medicines held awaiting return. We spoke with staff and their description of the process for returning medicines matched the provider's policies and procedures. We looked at the medication administration records (MAR) for eight residents. We found that records of medicines being administered matched those identified in in the care plans. No signature gaps evident for the ones we looked at. Some handwritten MAR charts didn't contain two initials when being checked (details obtained for evidence). On discussion with the manager they told us they would investigate this with staff. We saw where medicines were not administered; the records indicated the reasons for this. Our observations of staff during the medication round found that they were administering medicines safely and in line with prescribing instructions. We found residents were informed by staff of what was happening prior to administration and we saw that staff ensured the medication trolley was locked and safe when not being attended. We saw where residents have been identified as requiring their medicines 'as and when required' or PRN; we found these to be managed appropriately. Our discussions with staff assured us they understood the provider's policies and

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

procedures in this area. We looked at the residents' care plans and found that reviews of PRN medicines were taking place on a regular basis. We saw that records of resident's prescriptions were kept and a current copy of the British National Formula (BNF) was accessible.

We found that the records for Controlled medication (Controlled Drugs CD) were accurate and reflected the quantities of medicines held. The storage and administration of controlled drugs was in line with the provider's policies and procedures. We found consideration had been given to the placing of patches, to ensure residents did not receive double doses. The sample of controlled medication we looked at were correct. We found all controlled medication was stored and locked away appropriately.

We found systems in place for the safe disposal of controlled drugs. We spoke with staff regarding their understanding of how to administer and safely dispose of controlled drugs. Their description assured us they were ensuring residents medicines were being administered safely. We saw the senior care worker administering residents' medication safely at lunchtime in the dining room and in other parts of the home.

We spoke with staff regarding how they would deal with an adverse medication incident. Their description of the actions they would take matched the provider's policies and procedures. We found for those residents who were responsible for their own medication, we found appropriate systems in place for the assessment, safe storage, and handling, whilst maintain the residents' independence.

We looked at the provider's records of training and found that all staff had received recent training in the safe handling of medicines. We saw that prior to staff undertaking medication administration, their competency was checked. For example, MV: 3/6/21 and next review: 24/5/22. We saw copies of completed medication audits documentation that had been completed. For example, Medication audit dated: 1/8/21 and 8/8/21. We looked at

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.		
		documentation relating to the application of medication creams. We found that these were being applied, signed for and recorded appropriately. We looked at a sample of medication cream dispensers and tubes and we found these didn't always have a date of opening and date of discard recorded on them. We spoke with the manager about this and they told us they would review the process for these. This means that there are systems in place to manage, store, administer and document resident's medication to ensure residents are protected. See the recommendations given regarding covert medication administration. Two initials are required for all handwritten MAR charts. Opening dates and discard dates need adding to medication cream dispensers, tubes, and containers.

Standard Three: People who use services are supported by competent staff: People are supported and cared for by sufficient numbers of staff who are suitably recruited and sufficiently inducted and trained to provide them with the knowledge, skills and experience to be competent and professional.

3.1 Robust recruitment processes are completed with structured probation, supervision and appraisal arrangements in place for staff in line with Policies and Procedures

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We looked at a sample of staffing files [4] and we found that all appropriate checks have been completed. For example, obtaining 4 forms of identification, Disclosure barring service (DBS) checks. We found completed copies of staff induction programmes. Also, references from past employers. There are identification photographs on the staffing files. We spoke with care staff and they told us they do feel supported by the management. We spoke with the management about supervision and appraisals for the staffing team. Asking how they provide support. They told us they received formal supervision every 2 months. We looked at supervision records [4]. We found that the timescales for completion of supervision sessions is approximately every 2 months. We found that staff do receive an annual appraisal. We also found that staff meetings are held on a regular basis. Care staff told us the management have an open-door policy, so they can speak with a member of the management as and when needed. During our visit to this service we saw evidence to suggest the open-door policy works well. This means structured supervision and appraisal arrangements are in place for staff. Staff meetings are held. Staff can meet with the management when they wish (the management has an open-door policy).

3.2 Staff have the knowledge, experience, qualifications and skills to support the service users.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure all outstanding refresher training courses are arranged, attended, and completed by the staff that require them.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was good. We observed the care practices of staff. We found they understood the needs of residents, and we found they were responsive and person-centred in their actions. We spoke with three care staff about the specific needs of residents. They were able to describe to us the residents identified needs and how they support them. Training records and statistics seen. There are some gaps in training figures. However, the manager told us they were in the process of actioning these. For example, GHH: Fire safety awareness and Dignity and respect. We looked at the training records, provided by the manager, and found staff had completed compulsory and appropriate training needed within the last 12 months. This means residents can be assured that the staff members delivering their care has all the relevant knowledge and experience they need to provide safe care and effective care. Some gaps within refresher training is being addressed by the management.

3.3 Staffing levels for the service are determined and deployed according to people's assessed needs.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We spoke with the home manager regarding how they determined the number of staff members required. They told us they use dependency assessments.

3.3 Staffing levels for the service are determined and deployed according to people's assessed needs.		
		We looked at the dependency assessments for residents and found these to be an assessment of the needs of the person. We looked at the staff rota and found the staff planned to be working on the day of our visit matched those who were at work. We looked at how staff were deployed around the care home and found staff were well distributed. Staff rotas documented the same staffing levels at weekends. We obtained copies of the completed dependencies for this month and found these are a calculation of the staffing hours needed to manage the care needs of all residents who reside at the home. We looked at how meaningful group and individual activities were planned. We found activities were planned and the staff were available to facilitate these activities. We spoke with residents regarding how they spent their time. They told us there is something happening in the home each day if you wish to get involved. This means staffing levels for the service are determined and deployed according to people's assessed needs. Staffing rotas devised and social activities for residents are planned and provided.

Standard Four: Services are managed effectively: People receive high quality care through an effectively managed service. The provider/manager takes responsibility, is accountable for their actions, and has an effective system for identifying, assessing and monitoring the quality of the service provision.

4.1 People receive high quality care through an effectively managed service.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We spoke with residents and asked them if they knew who the home manager was. They told us they were aware of who the manager was and spoke with them most days. We looked at the provider's CQC registration on our visit and found that care was delivered in line with the registered regulated activities. We found that the home manager was registered with the Care quality commission (CQC). We looked at the manager's qualifications, experience and training and found this to be appropriate, and suitable to lead the team. The staff we spoke with told us the manager was very supportive. Our observations of the home manager found they were able to lead the team. This means the service and the manager is registered with the care quality commission (CQC). A business continuity plan is in place.

4.2 There is an effective system for identifying, assessing, monitoring the quality of service delivery.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We found evidence of comprehensive auditing processes in place to monitor quality of service delivery. We found the manager use findings from audits to form an action plan with measurable outcomes, realistic timescales and who is responsible to drive completion, we found the results from findings within the audits are used to produce reports to inform the owner of the service. We found evidence that audits had been completed on a regular basis, with overarching annual review to inform the organisation. Example, we saw are: Infection prevention and control audits, Medication audits and many others. We asked the provider to comment on how residents are consulted about the running of the service. They told us they hold meetings. We looked at the minutes of resident's, relative's and staff meetings and found these had been held regularly. Quality assurance surveys are completed (questionnaires). We were provided with the documentation following the most recent assessment. This means there is a system for identifying, assessing, monitoring the quality of service delivery and risks to health, welfare, and safety of residents. Quality assurance questionnaire surveys are completed and evaluated.

4.3 There is an effective system for identifying, receiving, handling and responding to and learning from complaints and concerns raised.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We spoke with residents and asked them whether they knew who they would make complaints to or raise their concerns if they weren't happy with the care they received. One resident said, "I know who to contact". We looked at the provider's complaints procedure and found this contained timescales, the responsible person and contact details for Care quality commission (CQC). We saw copies of the complaint's procedure on display in the care home. We looked at residents, relatives and staff minutes of meetings and found there were opportunities to raise concerns. We found records relating to any complaints had been addressed appropriately. This means there is an effective system for identifying, receiving, handling, and responding to and learning from complaints.

4.4 How is technology used to enhance the delivery of effective care and support?		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. Computers are used to send emails by the manager and care staff. We spoke with the manager. We asked them whether they use any technology. They told us residents use Skype/Zoom and FaceTime for contacting relatives, family, and friends if they wish too. We were told that I-pads are used. We looked at one and found that these are also used by residents and for taking and storing

4.4 How is technology used to enhance the delivery of effective care and support?

		photographs. Staff told us residents sometimes use them for playing games. The home has an electronic call bell system in place. This means residents do have access to technology as and when needed.

Standard Five: Environment is safe and homely: People live in an environment which is clean, safe and personalised.

5.1 The accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. There are effective cleaning and maintenance schedules in place which ensure suitable standards of living are maintained.

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was excellent. We spoke with residents [2] regarding the physical environment of the care home. They said, “Nicely decorated” and “Newly painted dining room”. We found what we had been told was true. We looked around the care home, at communal spaces, residents’ rooms, bathrooms, and toilets. We found the premises to be maintained to a good standard. We looked at the exterior and grounds and gardens of the care home, and we found these to be maintained to a good standard. We found that resident can access the garden when they wish. We saw suitable garden furniture and seating available. We found the garden to be a pleasant space for residents. We looked at a sample of cleaning schedules and found these show details of how to clean effectively. Cleaning schedules also show that night staff carry out cleaning tasks. We looked and found that staff have access to hand washing, toileting and/or bathroom facilities. Records show that each resident’s room is deep cleaned on a regular basis. Staff told us if a resident moves out or passes the room is deep cleaned and decorated. We saw a sample of completed maintenance schedules. The maintenance staff member attended at the time of this visit. This means the accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being.

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.

Score	Recommendations:	Observed Evidence
Good	Ensure all recommendations given by the (NHS IPC CCG) community matron are addressed within the set timeframes stipulated.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2021/2022. Our judgement was that the standard was good. We looked at systems in place and found there is a system for managing and monitoring health and safety within the service. We found staff adequately were informed and educated about general health and safety and infection control policies, procedures, and government guidance within the home, and this also includes Coronavirus (Cvd19). We checked the training completed by staff and found staff had completed training in these areas. For example, Infection prevention and control (IPC), COSHH and RIDDOR training and training about Coronavirus (Cvd19). We were told by the manager that they keep in close contact with the NHS Infection prevention and control team and Public Health England (PHE). Records seen support this. Infection Prevention and Control (NHS CCG) completed an audit at this service on: 21/09/2021 and we found several recommendations were given. We saw evidence to show that the manager is working through these with timescales. Records seen support completion of some recommendations and other are still in the process of being actioned. For example, Room 14 “Ensure that as well as a daily clean all staff are aware of their responsibility to clean commode pots and frames after each use. Suitable cleaning products should be available for staff to do this” Timeframe for this to be actioned is the end of November 2021 by the manager and the team leaders. We looked at equipment and found these had been regularly checked and maintained. Staff are aware of how to report any maintenance issues. We found where issues are identified all measures are followed to rectify them with clear actions documented. The person responsible for maintenance attended the home at the time of our visit. We found fire assessments had been completed and fire equipment checks had been completed as required. We saw records regarding the completion of Infection prevention and control (IPC) audits and action plans are generated when required.

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.

		This means there are systems in place to help prevent and control of health associated infections. The premises are clean, well maintained and smell pleasant. The staffing team have received the appropriate training. Equipment is mostly well maintained. Each resident has a personal emergency evacuation plan (PEEPS) in place, which are reviewed regularly. Recommendations given by (NHS IPC CCG) community matron are completed within the set timeframes given.